

**PATIENT INFORMATION**

Name *(Last, First)*: \_\_\_\_\_

Street Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

SS #: \_\_\_\_\_ Sex *(circle one)*: M F

Referring doctor: \_\_\_\_\_

Primary care doctor: \_\_\_\_\_

Neurologist: \_\_\_\_\_

ENT *(ear, nose, throat doctor)*: \_\_\_\_\_

Pain Management doctor: \_\_\_\_\_

**CONTACT INFORMATION**

E-mail *(we will be providing you with educational and coaching material throughout your care with us. We will not give your e-mail address to others)*: \_\_\_\_\_

Phone- Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

**INSURED PERSON** (if not patient)

Name *(Last, First)*: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SS #: \_\_\_\_\_

**EMERGENCY CONTACT**

Name *(Last, First)*: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone- Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION**

I authorize Nasha Holt, MD to share my medical records and health information with other professionals directly involved in my care.

\_\_\_\_\_  
*(Please sign here)*

\_\_\_\_\_  
Date

**DISCLOSURE OF PATIENT PROTECTED HEALTH INFORMATION**

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication or PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home. Please put a check mark to indicate how you wish to be contacted about lab results or other PHI:

**HOME:**

- O.K. to leave messages with detailed information
- Leave message with call-back number only
- O.K. to mail to my home address
- O.K. to fax to this number: \_\_\_\_\_

**WORK:**

- OK to leave messages with detailed information
- Leave message with call-back number only

**CELL:**

- OK to leave messages with detailed information
- Leave message with call-back number only

**People I authorize Nasha Holt, MD to share my PHI with:**

- Spouse: (provide name) \_\_\_\_\_
- Parent: (provide name) \_\_\_\_\_
- Child: (provide name) \_\_\_\_\_
- Other: (provide name) \_\_\_\_\_

**OFFICE POLICIES**

In order to continue to serve our valued patients, we have adopted the following policies:

1. **CANCELLATIONS:** We require at least a 24 hour notice for cancellation of appointments so that we may offer your appointment time to another patient.
2. **TARDINESS:** If you are 10 minutes late or more, you may be rescheduled in order to accommodate our other patients' scheduled appointment slots.
3. **PAYMENT:** Payment is to be made in full at the time of each visit.
4. **PRESCRIPTION REFILLS:** Refill requests must be made at least one week in advance and should be faxed to our office from your pharmacy. This reduces medication errors from phone messages.

*I have read and understand the policies set by Nasha Holt, MD and Headache Institute of Texas and agree to the terms.*

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date